Texas Department of Health
Bureau of Women's Health
Ambulatory Maternity Standards
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The Texas Department of Health Ambulatory Maternity Standards emphasizes preconception care and ongoing antepartum risk assessment with the importance of client education and prevention.

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****The Texas Department of Health (TDH) Quality Care: Client Services Standards for Public Health and Community Clinics (June 1997) is incorporated and made a part of the Ambulatory Maternity Standards.**

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CLINICAL

A. Health Record Statement:

The contractor/provider maintains a complete and accurate record of each prenatal/postpartum client's health care.

Policy:

The contractor/provider ensures a complete and legible client health record.

Procedure –	***Evaluative Criteria –***
All client records are arranged in a consistent chart order.	Evidence of a consistent chart format/organization.
1. The client's record includes the following appropriate documentation a. Client identification	Evidence of complete, legible, and accurate documentation of all components.
b. Preferred language/method of communication	
c. Where and how to contact the client (to facilitate continuity of care and assure confidentiality)	
d. History (as detailed in B. Health and Risk Assessment)	Allergies prominently noted on the client record.
e. Physical examination (as detailed in D. Medical Evaluation)	Documentation of an appropriate physical exam
f. Results of screening, findings of physical exam and other diagnostic tests	
g. Assessment	
h. Plan of care, including education/counseling, treatment and recommended subsequent visits and follow-up	Documentation of recommended subsequent/follow-up visits.
i. Referrals made and their outcome(s)	Documentation of recommendations for referrals.
j. Each entry signed and dated by the provider or designee	All entries are dated (month/day/year) and signed with the appropriate credentials by providers and provider designees.
k. Informed consent forms for services. 1. All clients and/or guardians must provide signed and witnessed consent for services initially.	Blanks on appropriate consent form(s) are filled in, properly signed, and witnessed.

	2. All clients must provide signed and witnessed consent for prescriptive family planning methods. 3. All clients and/or guardians must provide signed consent for immunizations	
l.	A consistent mechanism to prominently document and track health and social problems/issues to promote continuity of care.	Use of a problem list.
m.	Indirect encounters, e.g. phone calls	Documentation of telephone calls, correspondence and other indirect encounters to client or to other providers re: client's care, which are properly signed and dated.

CLINICAL

B. History and Risk Assessment Statement:

All prenatal/postpartum clients have a complete health and social history/risk assessment completed initially and updated at each subsequent visit.

Policy:

The contractor/provider ensures complete client health and social history/risk assessment is obtained.

Procedure –	***Evaluative Criteria –***
The health history/risk assessment and social history/risk assessment includes the following: **1. The medical history/risk assessment** a. Chief complaint b. Current history c. Significant past illness d. Hospitalizations/surgeries/biopsies with dates e. Medications including over the counter (OTC) as well as alternative and complementary medicines f. Allergies, sensitivities or reactions to medicines or other substance(s) g. Family history (to include genetics) h. Gynecological history i. Obstetrical history j. Sexual behavior history, including family planning practices k. Mental health history, to include depression and suicidal thoughts or gestures l. Nutritional history/assessment m. Immunization history/assessment n. Occupational hazards or environmental toxin exposure o. Exercise/physical activity/assessment	Evidence of health history and risk assessment (both medical and social) in the record. Documentation of medical history/risk assessment.
2. The social history/risk assessment a. Home environment b. Tobacco/alcohol/street drugs c. Trauma/Domestic violence/abuse (physical, emotional or sexual abuse) d. Education e. Financial resources/insurance	Documentation of social history/risk assessment. Texas Family Code, Chapter 261 and Rider 14

CLINICAL

C. Preventive Health Education/Counseling Statement:

All prenatal/postpartum clients receive preventive health education/counseling.

Policy:

The providers of medical care provide preventive education/counseling based on client's history/risk assessment and need.

Procedure –	***Evaluative Criteria –***
All clients receives preventive health education/counseling that covers the following appropriate areas: **1. Prenatal** a. Availability of prenatal testing with risks/benefits b. Medicaid referral c. WIC referral d. Warning signs of pregnancy appropriate to gestational age e. When and where to obtain emergency care f. Fetal movement appropriate to gestational age g. Physical changes of pregnancy/fetal growth h. Prenatal vitamins with folic acid i. Comfort measures j. Physical activity/exercise k. Sexual activity l. Toxoplasmosis precautions (cats/raw meat) m. Adverse environmental exposure at work and at home n. Infant feeding choices, breastfeeding should be promoted o. Preparation for labor and delivery, childbirth classes p. Signs and symptoms of preterm labor, 24-36 weeks q. Delivery arrangements r. Braxton Hicks labor and signs and symptoms of true labor s. Preparation for parenthood and arrangement for health care provider for infant health care	Documentation of education provided based on health risk assessment or client need. **Documentation that each item 3 through 9 is presented at appropriate times during course of prenatal care.*

t. Postpartum care and postpartum depression u. Preconception counseling.	
2. Postpartum a. Physiologic changes b. Signs of common complications/warning signs. c. Care of the breast, perineum and abdominal incision d. Physical activity/exercise e. Infant feeding. (Breastfeeding should be encouraged and supported) f. Resumption of sexual activity including appropriate contraception g. Preconception counseling h. Case management assessment	Documentation in the health record. **Documentation that each item 3 through 9 is presented at appropriate times during course of postpartum care.*
3. Newborn Care a. Feeding. (Breastfeeding should be encouraged and supported) b. SIDS/sleep position c. Newborn screens d. General care of infant e. Bonding f. Child health appointments/immunizations g. Normal growth and development h. Infant car seats to include installation and use	*Documentation in the health record.
4. Nutrition a. Healthy diet b. Weight management c. Folic acid d. Calcium	*Documentation in the health record.
5. Health promotion a. Immunizations b. Dental c. Physical activity/exercise d. Family planning e. Breastfeeding encouragement and support	*Documentation in the health record.
6. Violence a. Family/domestic/trauma b. Gang	*Documentation in the health record.

7. Injury prevention a. Firearms b. Car safety restraints/Infant car seats to include installation and use c. Home safety	*Documentation in the health record.
8. Behavior a. Substance abuse, e.g. tobacco, alcohol, chemicals and drugs b. Safer sex practices c. Depression/Postpartum depression d. Suicide	*Documentation in the health record.
9. Other education based on specific problems or health history/risk assessment.	*Documentation in the health record.

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D. Medical Evaluation (physical examination) Statement:

All prenatal/postpartum clients receive prenatal/postpartum care according to written and established guidelines.

Policy:

All initial and routine follow-up prenatal/postpartum client's are provided an appropriate physical exam, interventions, and appropriate lab according to visit.

Procedure –	***Evaluative Criteria –***
1. Initial Prenatal Physical Examination a. Height b. Weight c. Blood pressure d. Fetal heart rate (>12 weeks) e. Heart f. Breast/Axillae g. Abdomen h. Fundal height/uterine size i. Pelvic and cervical exam j. Other systems as indicated by history/risk assessment.	Health record. Documentation in the client record of an initial physical exam that includes the identified components. If the provider is using SOAP notes, each component of the exam must be documented. Observation of an initial P.E. that includes the identified components.
2. Scheduled/Routine follow-up Prenatal Physical Examination a. Weight b. Blood Pressure c. Fetal heart rate d. Fundal height e. Fetal lie, if >30 weeks f. Other systems as indicated by history/risk assessment.	Documentation in the health record.
3. Postpartum Physical Examination a. Weight b. Blood Pressure c. Breast/Axillae d. Abdomen e. Pelvic and cervical exam f. Other systems as indicated by history/risk assessment.	Documentation in the health record.

CLINICAL

E. Laboratory tests and interventions Statement:

All prenatal/postpartum clients receive prenatal/postpartum care according to written and established guidelines.

Policy

All initial and routine follow-up prenatal/postpartum client's are provided an appropriate physical exam, interventions, and appropriate lab according to visit.

Procedure –	***Evaluative Criteria***
1. Initial Prenatal Laboratory Tests and Interventions	Documentation of laboratory tests and interventions in the health record.
a. CBC or hemoglobin and/or hematocrit	
b. UA	
c. Urine culture/screen if indicated	
d. Syphilis (VDRL) serology	Health and Safety Code 81.090
e. Hepatitis B Antigen (HbsAg)	Health and Safety Code 81.090
f. HIV (unless refused by client and then must be referred to anonymous testing facility)	Health and Safety Code 81.090
g. Blood type/group	
h. Rh type and antibody	
i. Rubella serology if not previously documented in chart.	
j. TB skin test (per risk)	Documentation that risk was assessed.
k. Cervix: Pap smear (if none documented within 1 year)	
l. Cervix: Gonorrhea (per risk)	
m. Cervix: Chlamydia (per risk)	
n. Genetic screening (per risk)	
o. Other lab as indicated by history/risk assessment or physical.	

2. Scheduled/Routine Laboratory Tests and Interventions **Each Visit** UA: glucose and protein **15 – 18 weeks** Offer MSAFP – triple markers **24-28 weeks** a. Diabetes screen b. Hct c. GTT (if diabetes screen abnormal) d. D(rh) antibody screen for Rh negative e. D immune globulin (RhIG) (Rhogram) given at 28 weeks unless contraindicated. Other lab as indicated by history/risk assessment or physical.	Documentation of laboratory tests and interventions in the health record.
Postpartum Laboratory Tests and Interventions a. Hemoglobin and/or hematocrit b. Rubella screen if not previously documented in the client record. (If nonreactive, need to immunize postpartum) c. Other lab as indicated by history/risk assessment or physical.	Documentation of laboratory tests and interventions in the health record.